

HIPAA RELEASE FORM

Request to Receive Copy of Your Health Information

As a patient of Orsini, you are entitled under federal law to access your protected health information ("PHI"), maintained in a "designated record set." In order to process your request for access to this information, please complete this form and submit it by mail to: Orsini, Attn: Patient Care Privacy Officer, 1111 Nicholas Blvd, Elk Grove Village, IL 60007, or by email to patientcare@orsinihc.com.

Patient Name (printed): _____ **Date of Birth:** _____

Address: _____

City, State, Zip: _____

Please indicate what information you wish to receive (such as all pharmacy records or pharmacy records for certain dates of service and/or billing records):

Please indicate **how you would like to receive** the copy of your records:

send my records to the following address (records will normally be sent by first class mail)

mail me a hard copy of my records; or

mail me an electronic copy of my records (such as on a thumb drive)*

send the copy via facsimile to the following number: _____

send the copy to the following e-mail address*: _____

*** PHI sent by unsecure (meaning unencrypted) email or on an unencrypted device, such as a thumb drive, if applicable, could be read or accessed by a third party. By requesting to receive my PHI by email or to receive an electronic copy, I am accepting this risk.**

Orsini is permitted to charge certain reasonable, cost-based fees in connection with providing copies of PHI. If applicable to this request, Orsini will contact you with an estimate of such fees and give you the opportunity to revise your request.

Signature

Date of Signature

If not signed by the patient:

Name of person signing (printed):

Description of relationship (i.e., guardian):

The Office for Civil Rights and Office of the National Coordinator for Health Information Technology collaborated to develop these model Notices of Privacy Practices.